

Welcome Volunteer Membership Applicant:

We welcome you to the Culpeper County Volunteer Rescue Squad. We are an equal opportunity organization, and do not and will not discriminate based on race, religion, national origin, sex, age, handicap, marital status, sexual preference, or status as a disabled veteran.

Volunteering as an EMT or Paramedic is a challenging but rewarding experience. Along with serving your community directly and making a difference every day, there are certifications to maintain, training that needs to be completed regularly and station maintenance that needs to be done. Becoming a member involves a significant amount of time and dedication. Please consider this carefully before beginning the application process.

Our active members receive several benefits: Free uniforms, training opportunities and education allowances. Intangible benefits include the camaraderie of the prehospital family and a solid foundation for a career in EMS.

For our younger volunteers, ages Sixteen (16) to Eighteen (18), we operate a Junior Member program. Our Junior Members are the future of our organization, and we encourage their participation.

In addition, we could not operate a volunteer organization without our Associate Members. They assist with administrative duties and fundraising for the organization. If you want to help your community without getting on an ambulance, this option may be perfect for you.

If you have any questions regarding the application process, wish to schedule a ride along, or about the status of your application, please feel free to contact a member of the Personnel Committee at 540-825-2247, or membership@culpeperrescue.com.

We appreciate your interest in serving as a Culpeper County Volunteer Rescue Squad volunteer member and look forward to receiving your application.

Sincerely,

Matthew Komar
Chief

SQUAD

This packet includes everything you will need to apply as a volunteer member. The following is an explanation of the complete application process.

1. Complete all sections of the attached application and related documents.
2. Return the completed application to the Culpeper County Volunteer Rescue Squad at 1121 North Main Street, Culpeper, VA 22701, Attention: Personnel Officer. Upon receipt of the above information and the completed application form, you will be contacted for an interview with the Personnel Committee.
3. Once the interview has been completed, your application will be brought before the membership of the Organization during the monthly business meeting for a vote. The Personnel Committee will make a recommendation to the Organization: (1) to grant membership with probationary status, (2) to deny the membership application.
4. Once membership is granted, you will begin a probationary period of six to twelve months. During this time, you will receive the necessary pre-requisite training for Emergency Medical Services.
5. After your probationary period, your application will be reviewed by the Personnel Committee and then brought before the Organization for final approval. At this time, the Personnel Committee will speak on your status as a probationary member and make a recommendation to the Organization: (1) to grant full membership status, (2) extend the probation period for up to an additional 6 months, or (3) terminate the membership.



SQUAD

REQUIREMENTS FOR MEMBERSHIP:

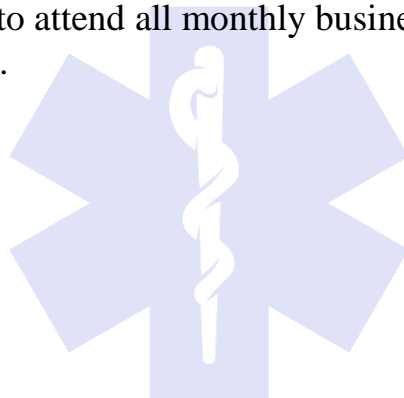
1. Applicant must be sixteen (16) years of age or older to apply as a volunteer member.
2. Application must be filled out in full, and returned to Culpeper County Volunteer Rescue Squad at 1121 North Main Street, Culpeper, VA 22701

TYPES OF MEMBERSHIP:

1. Senior (18 years of age or older):
 - a. This requires twenty-four (24) duty hours on a monthly recurring basis.
 - b. This membership requires a current EVOC (Emergency Vehicle Operators Course) and/or EMT certification.
2. Junior (16 to 18 years of age):
 - a. Parental consent is required. No duty hour requirement.

REQUIREMENTS OF MEMBERS:

1. Each member is responsible for maintaining required certifications and complying with all training requirements of the Organization.
2. Each member is expected to meet the minimum requirements for continued membership; this includes meeting a predetermined number of hours at the station based on the respective membership level.
3. Each member is expected to always be kind, courteous, honest, and a positive representative of the Organization. Each member is expected to abide by and uphold the rules, regulations, and by-laws.
4. Each member is expected to attend all monthly business meetings, unless there are extenuating circumstances.



SQUAD

Application for General Membership

PERSONAL

| | | | | |
|--|----------------|--------|---|--|
| Last Name: | | First: | Middle: | Date: |
| Street Address: | | | | Home Phone: |
| City: | State: | Zip: | Business Phone: | |
| How long have you lived at this address? | | | Sex: | Mobile Phone: |
| | | | <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Social Security Number and Drivers License #: | Email Address: | | | Date of Birth: |
| Are you a citizen of the United States or a legal resident alien? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you over 18 years of age? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you currently hold a valid driving license? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| How did you learn of our organization? <input type="checkbox"/> Referral <input type="checkbox"/> Newspaper <input type="checkbox"/> Flyer <input type="checkbox"/> Fundraiser | | | | |
| <input type="checkbox"/> Another Fire and Rescue Station? Please list the station name: | | | | |
| <input type="checkbox"/> Other? Please explain: | | | | |

Failure to provide complete information on the form could delay the processing of your application.

RESCUE



SQUAD

EXPERIENCE

| | | | |
|--|--|----------------|-------|
| Have you ever filed an application with Culpeper County Volunteer Rescue Squad? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If so, when? | | | |
| Have you ever been denied membership to a fire and/or rescue department? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If so, please explain: | | | |
| Have you ever been discharged for misconduct, or asked to resign from a fire and/or rescue department? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If so, please explain: | | | |
| Can you speak any foreign languages, including sign language? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If so, please list all languages: | | | |
| Do you have prior EMS experience? | <input type="checkbox"/> 911 <input type="checkbox"/> IFT <input type="checkbox"/> No | | |
| List all Fire/EMS/Medical certifications you have. | Can you provide a copy of all certifications? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Certifications | State | Certifications | State |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

EDUCATION

| School | Name and Location of School | Course of Study | No. of Years Completed | Did you Graduate? | Degree or Diploma |
|-------------|-----------------------------|-----------------|------------------------|---|-------------------|
| Graduate | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| College | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| High School | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Other | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

EMPLOYMENT

| | |
|---|---|
| Present Employer: | Telephone: () - |
| Address: | Employed (State Month and Year) From: To: |
| Name of Supervisor: | |
| State Job Title and Describe Your Work: | |
| Previous Employer: | Telephone: () - |
| Address: | Employed (State Month and Year) From: To: |
| Name of Supervisor: | Reason for Leaving: |
| State Job Title and Describe Your Work: | |
| Previous Employer: | Telephone: () - |
| Address: | Employed (State Month and Year) From: To: |
| Name of Supervisor: | Reason for Leaving: |
| State Job Title and Describe Your Work: | |

REFERENCES

Please list three references, not related to you by blood, or marriage, that you have known for at least two years.

| NAME | RELATION | WORK PHONE # | HOME PHONE # |
|------|----------|--------------|--------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |

Please list three additional references from any previous membership in a fire department or rescue squad.

| NAME | RELATION | WORK PHONE # | HOME PHONE # |
|------|----------|--------------|--------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |

EMERGENCY CONTACT

| | | | | |
|---|--------|---------------|-----------------|---------------|
| In case of an emergency, please notify: | | Relationship: | | |
| Address: | | Home Phone: | | |
| City: | State: | Zip: | Business Phone: | Mobile Phone: |

VOLUNTEER
RESCUE



SQUAD

GENERAL INFORMATION

Have you ever been convicted of a traffic violation (not including parking tickets), a misdemeanor, or a felony? Yes No

If yes, fully explain charge(s), date(s), verdict(s), and any terms or conditions. State whether felony or misdemeanor.

Are you currently under any pending indictment or charge? Yes No

If yes, indicate the date and nature of the charge, police agency, court and disposition:

Have you ever engaged in the use or sale of illegal substances? Yes No

If yes, please explain:

Do you have any medical issues or disabilities, which may interfere with your ability to fully perform all duties? Yes No
(This is including but not limited to: spinal problems, back problems, heart problems, etc.)

If yes, please describe:

Have you ever been or presently under a Doctor's care for ANY medical condition, mental disorder, or nervous condition? Yes No

If so, please explain:

Are you currently on disability? Yes No

If so, please explain:

Are you able to lift one hundred twenty-five (125) pounds? Yes No

RESCUE



SQUAD

ACCEPTANCE OF APPLICATION

I, the undersigned, certify that the information contained herein is true and complete to the best of my knowledge. I understand that should any statement I have made prove false, misleading, erroneous, it may result in the rejecting of my application or in my discharge from the **Culpeper County Rescue Squad, Inc.** I also agree to abide by and uphold the rules, regulations, and by-laws of the **Culpeper County Rescue Squad, Inc.**

I further agree to maintain patient confidentially in accordance with the Health Insurance Portability and Accountability Act (HIPAA) as explained to me.

Upon resignation or termination of my membership, I agree to return all items issued by **Culpeper County Rescue Squad, Inc.**, including but not limited to pager/radio, protective gear, uniforms and any other items entrusted to me.

*Print Full Legal Name: _____

*Signature: _____

*Date: ____/____/____

Any applicant under the age of 18 must have the consent of a parent(s) or legal guardian to become a member of the Culpeper County Rescue Squad, Inc and participate in the rescue squad activities.

I, the undersigned, hereby give consent for my (son or daughter)
_____ to become an active member of the Culpeper County
Rescue Squad, Inc. and to participate in any and all rescue squad activities.

*Print Full Legal Name: _____

*Parent/Legal Guardian Signature: _____

*Date: ____/____/____

SQUAD

AUTHORITY TO RELEASE INFORMATION

To Whom It May Concern:

I hereby authorize the President / Chief of the department, or any other authorized official of the **Culpeper County Rescue Squad, Inc.**, bearing this release, permission to conduct a personal background investigation which I know may include any information held, in my personal and training files from other departments if applicable. I further authorize **Culpeper County Rescue Squad, Inc.**, to conduct a criminal background check as well as a driver's license investigation.

This release is granted with full knowledge and understanding that information is for official use of the **Culpeper County Rescue Squad, Inc.**, and furthermore, that it may be used to terminate this application. None of the information obtained will be released to any other individual or agency without consent of the applicant.

I hereby release you, as custodian of such records, from any liability or damage of whatever kind resulting at any time because of compliance with this authorization.

Print Full Legal Name _____

Date _____

Signature _____



SQUAD



Virginia Department of Health > Emergency Medical Services > Regulation & Compliance Enforcement > Fingerprinting > Volunteer – Non-certified Member (e.g

VOLUNTEER – NON-CERTIFIED MEMBER (E.G. DRIVER, FIREFIGHTER)



To schedule a fingerprinting appointment, please follow these simple instructions. Your application cannot be finalized and a certification issued until you have completed your fingerprinting through Fieldprint.

1. Visit <http://fieldprintvirginia.com>
2. Click on the “**Schedule an Appointment**” button.
3. Enter an email address under “**New Users/Sign Up**” and click the “**Sign Up**” button. Follow the instructions for creating a Password and Security Question and then click “**Sign Up and Continue**”.
4. Enter the Fieldprint Code **FPV999NC** when requested.
5. Enter the contact and demographic information required by the FBI and schedule a fingerprint appointment at the location of your choosing.
6. At the end of the process, print the Confirmation Page. Take the Confirmation Page with you to your fingerprint appointment, along with two forms of identification.
7. If you have any questions or problems, contact Katie Hodges (kathryn.hodges@vdh.virginia.gov) at the Office of EMS.

If you are having difficulty accessing information on this page or website, please email us at Accessibility@vdh.virginia.gov.

BENEFICIARY DESIGNATION FORM

This form may be used for multiple Policies when designating the same beneficiary. Use a separate form when designating different beneficiaries for each Policy.

Indicate one of the following:

- New Insured
 Beneficiary Change
 Name Change: From: _____

Complete all of the following information:

| | | |
|--|---------------------------------|----------------------------------|
| Policyholder Name and Policy Number(s) <i>(Emergency Service Organization Name)</i> | | |
| <input type="checkbox"/> | _____ Policyholder _____ | _____ Policy Number _____ |
| <input type="checkbox"/> | _____ Policyholder _____ | _____ Policy Number _____ |
| <input type="checkbox"/> | _____ Policyholder _____ | _____ Policy Number _____ |
| <input type="checkbox"/> | _____ Policyholder _____ | _____ Policy Number _____ |
| <input type="checkbox"/> | Other _____ | |
| <input type="checkbox"/> | Other _____ | |

| | | |
|----------------|---------------------|---------------------------------------|
| Last Name: | First Name: | MI: |
| Date of Birth: | Date of Membership: | Social Security Number: / / |

I hereby designate the following beneficiary(ies) to receive any death benefit proceeds payable under the policies checked above. If this form represents a change of beneficiary, the present beneficiary designation(s) are terminated and the following designation(s) made:

| BENEFICIARY DESIGNATION – Primary Class | Relationship to insured | Date of Birth | Percent (must equal 100%) |
|--|-------------------------|---------------|---------------------------|
| <input type="checkbox"/> Mark if additional beneficiaries are listed on a separate paper and attached. (Name, address, phone number and/or email address of beneficiaries) | | | |
| | | | |
| | | | |
| | | | |
| BENEFICIARY DESIGNATION – Contingent Class | Relationship to insured | Date of Birth | Percent (must equal 100%) |
| (Name, address, phone number and/or email address of beneficiaries) | | | |
| | | | |
| | | | |
| | | | |

MINOR OR ESTATE AS BENEFICIARY: If death occurs and a minor child (a person under the age of majority) or your estate is designated as beneficiary, it may be necessary to have a guardian or legal representative appointed before any death benefit can be paid. This could mean legal expenses for the beneficiary and possible delay in the payment of any death benefit. Please take this into consideration when designating your beneficiary.

Insured's Signature: _____ Date: _____

Sample wording for Beneficiary Designations

| Class | Relationship of Insured | Percent |
|---|---|-------------------|
| One Beneficiary of a class: Jane Ann Jones | Spouse | 100% |
| Two or more Beneficiaries of a class: Arthur Leo Jones Grace Hays Jones | Father Mother | 50% 50% |
| Unnamed Children: Children of the Named Insured | | Split Equally |
| Unequal distribution: Grace Hays Jones Mary Jones Ford William Roger Jones | Mother Sister Brother | 50% 25% 25% |
| Insured's Estate | Executors or Administrators of the Insured's Estate | |

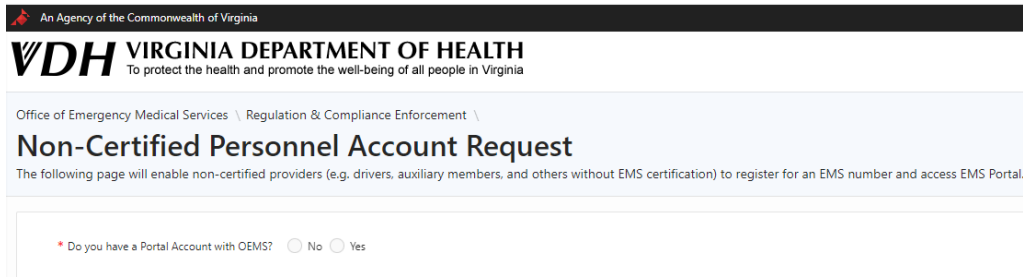
This form should be retained by the Policyholder with a copy to the insured.

*Primary Beneficiary is the person(s) who will receive the insurance proceeds.

** Contingent Beneficiary is the person(s) who will receive the insurance proceeds if the primary beneficiary is not alive at your death.

How to Affiliate as Non-EMS Certified Personnel

- 1) Click on the provided link: <https://vdhems.vdh.virginia.gov/emsapps/f?p=200:16>
- 2) Select “No” unless you have a portal account.



An Agency of the Commonwealth of Virginia

VDH VIRGINIA DEPARTMENT OF HEALTH
To protect the health and promote the well-being of all people in Virginia

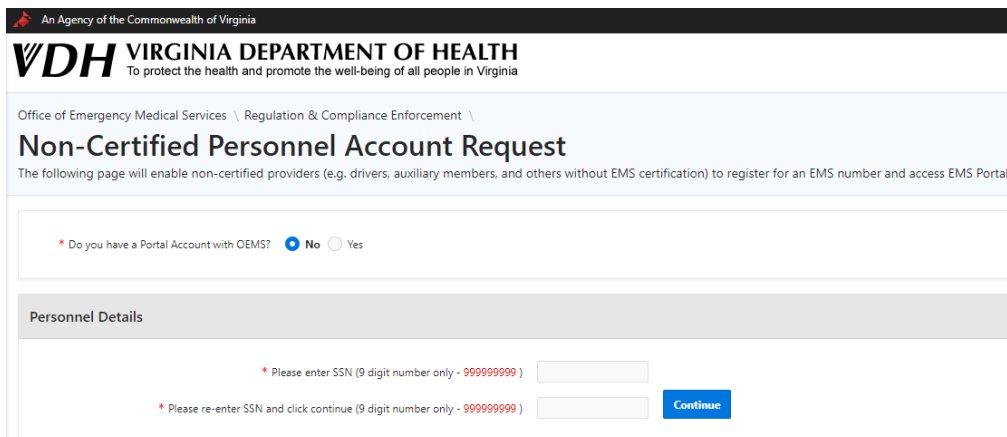
Office of Emergency Medical Services \ Regulation & Compliance Enforcement \

Non-Certified Personnel Account Request

The following page will enable non-certified providers (e.g. drivers, auxiliary members, and others without EMS certification) to register for an EMS number and access EMS Portal.

* Do you have a Portal Account with OEMS? No Yes

- 3) Enter your social security number.



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To protect the health and promote the well-being of all people in Virginia

Office of Emergency Medical Services \ Regulation & Compliance Enforcement \

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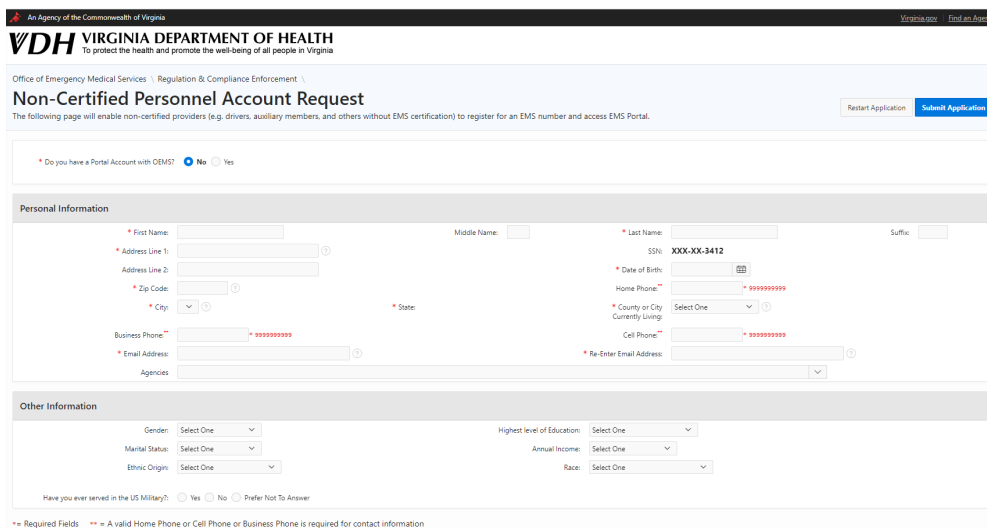
* Do you have a Portal Account with OEMS? No Yes

Personnel Details

* Please enter SSN (9 digit number only - 999999999)

* Please re-enter SSN and click continue (9 digit number only - 999999999) **Continue**

- 4) Complete the required information and click “Submit Application”.



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VDH VIRGINIA DEPARTMENT OF HEALTH
To protect the health and promote the well-being of all people in Virginia

Office of Emergency Medical Services \ Regulation & Compliance Enforcement \

Non-Certified Personnel Account Request

The following page will enable non-certified providers (e.g. drivers, auxiliary members, and others without EMS certification) to register for an EMS number and access EMS Portal.

* Do you have a Portal Account with OEMS? No Yes

Personal Information

* First Name: Middle Name: * Last Name: Suffix:

* Address Line 1: SSN: XXX-XX-3412

* Address Line 2: * Date of Birth:

* Zip Code: * State: Home Phone:

* City: * County or City Currently Living: * Cell Phone:

* Business Phone: * Re-Enter Email Address:

* Email Address:

Agencies:

Other Information

Gender: Highest Level of Education:

Marital Status: Annual Income:

Ethnic Origin: Race:

Have you ever served in the US Military?

* Required Fields ** A valid Home Phone or Cell Phone or Business Phone is required for contact information

- 5) You will receive an email prompting you to finish setting up your account.

Purpose: Use this form to request information from DMV records.

Instructions: Type or print clearly.

| REQUESTER INFORMATION | | | |
|--|-------------------------------------|-----------------------------|---|
| REQUESTER FULL NAME (last, first, mi, suffix) | | | FEDERAL TAX ID OR SOCIAL SECURITY NUMBER* |
| EMAIL ADDRESS | ORGANIZATIONAL AFFILIATION (if any) | TELEPHONE NUMBER | USE AGREEMENT NUMBER (if applicable) |
| STREET ADDRESS | | CITY | |
| STATE | ZIP CODE | ACCESS CODE (if applicable) | TNC CERTIFICATE NUMBER (if applicable) |
| REASON FOR REQUEST (be specific) (attach additional sheets if necessary) | | | |

* In accordance with Virginia Code §§2.2-803, 2.2-4807, and 58.1-520 et seq., the State Comptroller requires that the information requested on this application, including your social security number, be collected for debt set off collection purposes.

| GOVERNMENT REQUESTER | |
|---|-----------|
| IDENTIFY PROPOSED USE AND LEGAL AUTHORITY (Attach additional pages if needed. Attach letter with case information) | |
| <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> Special District <input type="checkbox"/> Other (identify below) | |
| IF OTHER, IDENTIFY TYPE | |
| <input type="checkbox"/> Check here if you are an attorney for the Commonwealth requesting information pursuant to your authority under Va. Code § 15.2-1627. | CASE DATE |
| <input type="checkbox"/> Check here if you are a public defender requesting information pursuant to your authority under Va. Code § 19.2-163.3. | |

| SUBJECT INFORMATION | |
|--|---|
| If you are requesting driving record information, the subject will be the person you are requesting information on. If you are requesting vehicle information, the subject will be the vehicle owner (if available). | |
| SUBJECT FULL NAME (last, first, mi, suffix) | <input type="checkbox"/> CHECK TO INDICATE SUBJECT NAME AND ADDRESS IS THE SAME AS THE REQUESTER ABOVE. |
| STREET ADDRESS | |
| CITY | STATE ZIP CODE |

| INFORMATION REQUESTED | |
|---|--|
| Check one or more boxes below to indicate the type of information you wish to receive. All data fields must be completed for Driving Record Information, Vehicle Information and Decedent Photo Requests. For Police Crash Reports provide as much information as possible. | |
| <input type="checkbox"/> DRIVING RECORD INFORMATION (Includes license history and conviction data) (complete SUBJECT INFORMATION above) | |
| SUBJECT DRIVER LICENSE NUMBER | or SUBJECT BIRTH DATE (mm/dd/yyyy) |
| REASON FOR REQUEST (Check one) <input type="checkbox"/> Insurance <input type="checkbox"/> Employment, School, or Military <input type="checkbox"/> Member/Applicant/Volunteer <input type="checkbox"/> Personal Use, Court, or Attorney <input type="checkbox"/> TNC | |
| An authorization from the subject is required for employers and others not authorized by Virginia code. I authorize the Department of Motor Vehicles to furnish, for this one time only, information pertaining to my driving record to the requester identified above. | |
| SUBJECT SIGNATURE | DATE (mm/dd/yyyy) |
| <input type="checkbox"/> VEHICLE INFORMATION (Includes vehicle description and registration data) (complete SUBJECT INFORMATION above) | |
| VEHICLE IDENTIFICATION NUMBER (VIN) | VEHICLE MAKE VEHICLE YEAR |
| <input type="checkbox"/> POLICE CRASH REPORT | |
| IMPORTANT NOTE: The Department may only release a full crash report in accordance with VA Code § 46.2-380. | |
| Check one or more boxes to indicate your involvement in the crash: | |
| <input type="checkbox"/> I was a DRIVER. | <input type="checkbox"/> I was a PASSENGER. |
| <input type="checkbox"/> I legally REPRESENT a person injured or involved in the crash. | <input type="checkbox"/> I was injured in the crash or as a result thereof (ex: injured pedestrian). |
| <input type="checkbox"/> I am the parent or legal guardian of a <u>minor</u> injured or killed in the crash. | <input type="checkbox"/> At the time of the crash, I owned a vehicle/property involved. |
| <input type="checkbox"/> I am the personal representative (guardian, executor, next of kin, etc.) of a person injured or killed in the crash. | |
| <input type="checkbox"/> I am an authorized representative of any insurance carrier reasonably anticipating exposure to civil liability as a consequence of the crash or to which a person has applied for issuance or renewal of a policy of automobile insurance. | |

INFORMATION REQUESTED (continued)

| | | | |
|---|---------------|---|-----------------------|
| CRASH DATE (mm/dd/yyyy) | TIME OF CRASH | CRASH LOCATION (highway or street name) | |
| CITY/COUNTY/TOWN WHERE CRASH OCCURRED | | DRIVER FULL NAME (last, first, mi, suffix) | DRIVER LICENSE NUMBER |
| 1. PASSENGER/PEDESTRIAN FULL NAME (last, first, mi, suffix) | | 2. PASSENGER/PEDESTRIAN FULL NAME (last, first, mi, suffix) | |
| 3. PASSENGER/PEDESTRIAN FULL NAME (last, first, mi, suffix) | | 4. PASSENGER/PEDESTRIAN FULL NAME (last, first, mi, suffix) | |

DECEDENT PHOTO REQUEST (requester *may* need to provide proof of death, i.e. copy of death certificate, executor papers, etc.)

| | | |
|--|---|---|
| DECEDENT FULL NAME (last, first, mi, suffix) | | DECEDENT DMV CUSTOMER NUMBER |
| DECEDENT BIRTH DATE (mm/dd/yyyy) | Requester's relationship to decedent (check one): | <input type="checkbox"/> Executor <input type="checkbox"/> Administrator |

OTHER INFORMATION (Be specific)

CERTIFICATION

I understand that it is unlawful to use information provided by DMV for any purpose other than the one stated. I certify that the information I have requested with this form will be used only for the stated purpose and that any personal information I receive will not be used for the predominant purpose of solicitation of prospective clients.

I agree that the information I obtain in response to my request is considered privileged and confidential. I agree that such information is subject to the restrictions upon use and dissemination imposed by (1) the Federal Drivers Privacy Protection Act (18 USC § 2721 et seq.), (2) the Government Data Collection and Dissemination Practices Act (Va. Code § 2.2-3800 et seq.), (3) the provisions of Va. Code §§ 46.2-208 through 210, 46.2.212, and 58.1-3, and (4) any successor rules, regulations, or guidelines adopted by DMV with regard to disclosure or dissemination of any information obtained from DMV records or files, and I agree to comply with such restrictions and understand that any violation may result in damages, civil penalties, criminal penalties or other relief permitted pursuant to Virginia law. If representing a government entity, I agree that the information obtained will not be used for civil immigration purposes or knowingly disseminated to any third party for any purpose related to civil immigration enforcement. Distribution of privileged information, as described at Va. Code § 46.2-208, to any third party is prohibited unless specifically identified and agreed to by DMV.

For volunteer organizations identified in Va. Code § 46.2-208(B), I also certify that the subject of the information being requested is a member of, applicant for membership in or applicant to be a volunteer with my organization.

I further certify and affirm that all information presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury, and I understand that knowingly making a false statement or representation on this form is a criminal violation.

| | |
|---------------------|-------------------|
| REQUESTER SIGNATURE | DATE (mm/dd/yyyy) |
|---------------------|-------------------|

CUSTOMER RECORDS FEES

| | | | |
|----------------------------------|--------|--|--------|
| Driving Record | \$9.00 | Supporting Documents (per page) | \$3.00 |
| Vehicle Record | \$9.00 | Motor Carrier Overweight Citation Record | \$8.00 |
| Police Crash Report | \$8.00 | Travel Emergency Photo Verification | \$9.00 |
| Decedent Photo | \$9.00 | Record Certification Fee (additional) | \$5.00 |
| Driver/Vehicle Application | \$9.00 | | |

PAYMENT METHODS

If you are mailing this request, DMV can only accept **check** or **money order** via mail.

| | | | |
|---|--------------------|---|--------------------------|
| <input type="checkbox"/> CHECK Made payable to DMV | ENTER CHECK AMOUNT | <input type="checkbox"/> MONEY ORDER Made payable to DMV | ENTER MONEY ORDER AMOUNT |
|---|--------------------|---|--------------------------|

DMV CUSTOMER SERVICE CENTER USE ONLY

| | |
|---|---|
| Proof of Requester's Identification | |
| <input type="checkbox"/> Valid Driver's License Number _____ | <input type="checkbox"/> Other Photo Identification _____ |
| If referred to Headquarters to Fill Request, Complete: CSR Name _____ CSC Name (not CSC number) _____ | Remarks/CSR Stamp Fee Charged \$ |